November 2006 No. 28

Long Term Care

Provider Bulletin

TEXAS Department of Aging and Disability Services

In This Bulletin

Check this quarter's LTC Bulletin for an update on the National Provider Identifier (NPI) and associated changes to the Long Term Care Claim Form 1290. Also included is an overview of a new project to replace the current TILE-based payment system with the federal case-mix model. It is important for providers who submit claims through third parties to read the "Third-Party Biller Enrollment" article on page 6: effective May 31, 2007, third-party billers (TPBs) will be required to contract with HHSC before submitting electronic claims. Other topics of note include the latest on the STAR+PLUS Program expansion, reminders of the top three reasons claims deny, and news about the new LTC Online Portal for submitting nursing facility and hospice forms without paper and faxes. ■

What's New?

LTC Online Portal Implementation

The LTC Online Portal, which replaced the DOS-based CFS software, has been implemented. Approximately 1,975 providers are currently using the LTC Online Portal to submit Client Assessment, Review, and Evaluation (CARE) Form 3652-A; Form 3618 Resident Transaction Notice, Form 3619 Medicare SNF Transaction Notice, Form 3071 Hospice Election/ Cancellation/Discharge and Form 3074 Physician Certification/ Recertification of Terminal Illness.

For questions about the LTC Online Portal, contact the TMHP Call Center/Help Desk at 1-800-626-4117. ■

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STAR+PLUS Program Expansion

STAR+PLUS, the managed care program for certain Medicaid recipients who are 65 years of age or older or who have disabilities, will expand to the Bexar, Harris/Harris Expansion, Nueces, and Travis Service Areas effective January 1, 2007. STAR+PLUS delivers health care and long-term services and supports (such as assistance with daily activities, home modifications, respite, and personal assistance) through health maintenance organizations (HMOs). Eligible adult Medicaid recipients include those who qualify for Medicaid based on supplemental security income (SSI) eligibility, who qualify for 1915(c) nursing facility waiver services, and those who are dual-eligible (enrolled in both Medicaid and Medicare). Eligible clients in these service areas will be required to enroll in a STAR+PLUS HMO. Children who are under 21 years of age and receive SSI can participate on a voluntary basis.

Medicare enrollment does not affect eligibility for STAR+PLUS. For STAR+PLUS participants who are dual-eligible, the STAR+PLUS HMO is only responsible for long-term services and supports. Primary acute care and pharmacy services for this population are covered through Medicare. Participation in STAR+PLUS will not change the way clients receive their Medicare services.

Providers of long-term services and support will no longer bill for services provided to STAR+PLUS members through the Department of Aging and Disability Services (DADS). All STAR+PLUS claims will be filled through the respective HMO with which the provider is contracted. All providers interested in contracting as a network provider for STAR+PLUS services should contact participating HMOs in their service area. Under the STAR+PLUS program, HMOs will authorize inpatient hospital stays, but TMHP will process claims for inpatient hospital services and support. The following HMOs have been selected to provide these services:

Service Area	STAR+PLUS HMOs
Bexar Service Area: Atascosa, Bexar, Comal, Guadalupe, Kendall, Medina, and Wilson Counties	Molina Healthcare of Texas, Superior HealthPlan, Amerigroup Community Care
Harris/Harris Expansion Service Area: Brazoria, Fort Bend, Galveston, Harris, Montgomery, and Waller Counties	Amerigroup Community Care, Evercare, Molina Healthcare of Texas
Nueces Service Area: Aransas, Bee, Calhoun, Jim Wells, Kleberg, Nueces, Refugio, San Patricio, and Victoria Counties	Evercare, Superior HealthPlan
Travis Service Area: Bastrop, Burnet, Caldwell, Hays, Lee, Travis, and Williamson Counties	Amerigroup Community Care, Evercare

In October 2006, HHSC began mailing enrollment materials, program information, and information about the available HMOs to clients eligible to participate in the STAR+PLUS program.

For more information visit the HHSC website at www.hhsc.state.tx.us/starplus. ■

2007 LTC User Manual will be Mailed to Paper Submitters

In January, the 2007 *Long Term Care User Manual for Paper Submitters* will be mailed to providers who submit claims on the Long Term Care Claim Form 1290. Providers may also access the manual on the TMHP website at www.tmhp.com.

The 2007 *Long Term Care User Manual for Paper Submitters* will include the new Form 1290 and updated instructions. Form 1290 has been revised to include the new National Provider Identifier (NPI). More information on the changes to Form 1290 can be found in the "National Provider Identifier (NPI) Update" article on page 4. Although use of the NPI is not required until May 23, 2007, providers may begin using the form as soon as it is published. ■

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In This Corner...

Top Three Reasons Why Claims are Denied

In response to questions from providers about the most common reasons claims are denied, the following article is being republished. Providers are encouraged to use and share this information with their staff to expedite the troubleshooting process when claims are denied.

An explanation of benefits (EOB) code gives the reason why a claim was denied. The top three reasons why claims deny are:

1. EOB F0077—"Billing code not submitted or cannot be determined." Claims deny with EOB F0077 when the Healthcare Common Procedure Coding System (HCPCS) code entered on the claim does not match what is on the individual's service authorization. To resolve this EOB, verify that:
   - The provider number is correct and includes all nine digits.
   - The individual's case/Medicaid number is correct.
   - The individual's name is spelled correctly.
   - The individual is eligible for service for the period billed. Submit a MESAV inquiry with TDHconnect or contact the caseworker to confirm eligibility.
   - The individual's level of service is appropriate for the code being billed.
   - The procedure codes billed are correct for the billing period. Refer to the most current LTC Bill Code Crosswalk for a listing of procedure codes.
2. EOB F0155—"Unable to determine appropriate fund code for service billed, verify Medicaid eligibility." Claims deny with EOB F0155 when the individual has lost eligibility, the wrong HCPCS code was entered on the claim, or an incorrect fund code was entered on the individual's service authorization. To resolve this issue, verify that the individual is eligible for services during the period billed. Submit a MESAV inquiry with TDHconnect (click the Med Elig/Med Nec tab) or contact the caseworker to verify eligibility, coverage code, category code, and program type code.
   - If eligibility or medical necessity for the dates entered in the MESAV inquiry has not been established, the Med Elig/Med Nec tab in TDHconnect will be grayed out/disabled. Contact the caseworker to establish eligibility for the individual.
   - If the coverage code is "W," the individual has temporary medical necessity. If it is "H," the individual has permanent medical necessity. If it is "O," the individual's medical necessity was denied.
3. EOB F0138—"A valid service authorization for this individual for this service on these dates is not available." Claims deny with EOB F0138 when the information provided on the claim does not match the information on the individual's service authorization. Some examples of this are when the individual's case/Medicaid number does not match the number on the service authorization; the provider number is incorrect; the individual was not eligible for services on the dates of service that were billed; or the service authorization does not cover all of the dates of service that were billed. To resolve this issue verify that:
   - The individual's case/Medicaid number is correct.
   - The provider number is correct and includes all nine digits.
   - The individual was eligible for services during the entire period billed. If even one day of service that is not covered by a service authorization is billed, the entire claim will deny.
     - Use TDHconnect to submit a MESAV inquiry and view the Service Authorization tab or contact the caseworker to establish eligibility for the individual.
     - If eligibility has not been established for the dates entered in the MESAV inquiry, the Med Elig/Med Nec tab will be grayed out/disabled. Contact the caseworker to establish eligibility for the individual. ■

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What's Coming Up?

New TILES to RUGS Project

In 1995, the 74th Legislature passed Texas House Bill 867 to mandate the use of a single resident assessment instrument. However, nursing facility providers in Texas continue to use two different resident assessment instruments:

- The Minimum Data Set Resident Assessment Instrument (MDS RAI) is currently used to gather and analyze information to improve a resident's quality of care and life, but not to determine provider payments.
- The Client Assessment, Review, and Evaluation (CARE) Form 3652-A is currently used to determine payments to certain LTC providers.

The TILES to RUGS project has been approved to manage the conversion from the state case-mix system for payments, which is based on the Texas Index for Level of Effort (TILE) model, to the federal case-mix system, which is based on the Minimum Data Set Resident Utilization Group (MDS RUG-III) model. TILE has 11 different levels of classification, while RUG has 34 levels (groups).

This project is expected to meet two goals:

1. Convert from the TILES reimbursement methodology to the RUGS reimbursement methodology using the Federal Minimum Data Set (MDS) specification version 2.0.
2. Convert from the use of the CARE Form 3652-A to the federal Resident Assessment Instruments (RAI) based on the MDS for the following programs:
   - Nursing facilities (certified facilities participating in Medicare or Medicaid)
   - Community Based Alternatives (CBA) Home and Community Support Services (HCSS)
   - Medically Dependent Children Program (MDCP)
   - Consolidated Waiver Program (CWP)
   - Program of All Inclusive Care for the Elderly (PACE)
   - STAR+PLUS
   - Hospice (Medicaid)

It is anticipated that the recently released LTC Online Portal system will be enhanced to include electronic submission of the MDS assessment forms that are required to calculate the RUG classifications. The web-based LTC Online Portal system offers many opportunities for technology improvements as part of the transition from CARE Form 3652-A usage.

Updates will be provided in future *Long Term Care Provider Bulletins* as additional information becomes available. ■

National Provider Identifier (NPI) Update

Do All Providers Need an NPI?

All entities that meet the definition of a health care provider, as described in Title 45 *Code of Federal Regulations* (CFR) §160.103, can apply for an NPI. Covered entities that meet the definition of health care providers will be required to obtain and use the NPI on standard transactions by the May 23, 2007, compliance date.

A long term care provider who provides only services that are not health-related (e.g., emergency response services, meals) is considered an "atypical provider." Although atypical providers do not have to apply for an NPI, their billing identification will also change. Effective May 23, 2007, atypical providers must use an atypical NPI in place of their contract number. An atypical NPI is created by placing a "D" in front of the atypical provider's contract number. For example, contract number 123456789 would become atypical NPI D123456789.

How to Apply for an NPI

There are two ways to apply for an NPI:

1. Providers can apply online at https://nppes.cms.hhs.gov/NPPES/.
2. Providers can prepare a paper application and send it to the entity that will be assigning the NPI (the Enumerator). The application and mailing address are available at https://nppes.cms.hhs.gov/NPPES or by calling 1-800-465-3203 or 1-800-692-2326 (TTY).

Additional NPI information, including directions

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on how to apply for an NPI, is available at https://nppes.cms.hhs.gov/NPPES and on the Centers for Medicare & Medicaid Services (CMS) website at www.cms.hhs.gov/hipaa/hipaa2. Nearly 60,000 Texas providers have already applied for their NPI.

New Authorization Referral Number

The Department of Aging and Disability Services (DADS) will institute the use of referral authorization numbers to validate specific provider/client service authorizations with the implementation of NPI. Providers who use one NPI to identify multiple contract agreements with DADS will be required to submit the referral number on all electronic claims. The use of referral numbers in TDHconnect will be covered in the provider training classes.

Form 1290 Changes

Form 1290 will be getting a new look! The NPI will be added to Form 1290 and published in the *Long Term Care User Manual for Paper Submitters* in January 2007. Although the use of the NPI is not required until May 23, 2007, providers may begin using the form as soon as it is published.

Important Notes

- Providers can have more than one NPI number, but DADS will allow only one NPI per contract (number) for payment.
- Providers should have received a letter in October 2006 that explained how to submit their NPI to DADS. Providers who did not receive this letter should email Report.NPI@dads.state.tx.us. ■

LTC NPI Implementation Workshops

TMHP is presenting a series of NPI Implementation Workshops to show you how things are changing with respect to claim submission, TDHconnect, and other processes. These ***free*** workshops are designed to increase providers' understanding of the NPI and the new processes that are being put into place to continue the efficient processing of claims. On the right is a schedule of dates and cities. Specific information about locations, dates, and times can be found at www.tmhp.com. You may have received a workshop invitation in mid-October with the information as well. You can easily register in one of three ways:

- Online through the TMHP website at www.tmhp.com.
- Faxing the invitation registration form to 1-512-506-7002.
- Mailing the invitation registration form to:

TMHP
Attn: Provider Relations
PO Box 204270
Austin, TX 78720-4270

Date	Location
11/14/2006	Midland
11/15/2006	Corpus Christi
11/15/2006	Austin
11/16/2006	Abilene
11/21/2006	Laredo
11/28/2006	Weslaco
11/28/2006	Amarillo
11/28/2006	Dallas
11/28/2006	Houston
11/29/2006	San Antonio
11/29/2006	El Paso
11/29/2006	Beaumont
11/29/2006	Lubbock

LTC NPI Conference Calls

LTC providers who are unable to attend the *NPI Implementation Workshop* are invited to participate in a conference call to learn more about the NPI. Callers will be prompted to provide the Conference ID number (right) at the time of the call.

There is no need to register for a conference call. However, lines are limited, and only the first 100 callers will be able to participate in each call.

Conference Calls Chairperson: Liz Sheehan	
Date	**Telephone Number**
01/11/2007	1-877-336-1840 ID # 1554824
01/25/2007	1-877-336-1840 ID # 1554824

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Third-Party Biller Enrollment

The 78th Texas Legislature enacted House Bill 2292, which teams the Texas Health and Human Services Commission (HHSC) with the Texas Department of State Health Services (DSHS) to combat provider, third-party, and client fraud.

Effective May 31, 2007, third-party billers must enter into a contract with HHSC before claims can be submitted to TMHP on behalf of any Medicaid provider. Third-party billers are persons, businesses, or entities (excluding state agencies) that submit claims on behalf of a provider, but are not the provider or an employee of the provider. For these purposes, an employee is a person for whom the provider completes an IRS Form W-2 that shows annual income paid to the employee. *All others meet the definition of a third-party biller.* The HHSC Office of Inspector General (OIG) will begin performing criminal background checks on all potential third-party billers that intend to submit claims to the Texas Medicaid Program, Medicaid managed care, and Children with Special Health Care Needs (CSHCN) Services Program. Criminal background checks will also be performed on any person or business entity that enrolls as a third-party biller and meets the definition of "indirect ownership interest," as defined in Title 1 *Texas Administrative Code* (TAC) §371.160.

Effective May 31, 2007, third-party billers must enter into a contract with HHSC before claims can be submitted to TMHP on behalf of any Medicaid provider... Providers can prepare for this change in policy by notifying their third-party billers...

Enrollment for third-party billers will begin on February 11, 2007. The third-party biller will be required to create an account on the TMHP website at www.tmhp.com and complete the Third-Party Biller Application. The information provided during the account creation process will be used to generate a Third-Party Biller Application that must be printed, signed, notarized, and submitted to TMHP. Once enrolled, third-party billers must send a request to TMHP for each provider whose claims they will submit. The provider must approve the request before any claims can be submitted. The privilege can be terminated by either the provider or the third-party biller at any time. Providers will be able to approve or deny the requests by using either their online Provider Administrator accounts or paper forms.

Providers can prepare for this change in policy by notifying their third-party billers that it will be necessary to complete the enrollment process beginning on February 11, 2007. Providers who have internet access can create a Provider Administrator account on the TMHP website at www.tmhp.com. Providers who do not have internet access will be able to request paper forms once the enrollment period has begun.

More detailed information about third-party biller enrollment will appear in the February *Long Term Care Bulletin*, No. 29. ■

Nursing Facility Services Provided to STAR+PLUS Clients Will be Billed Through TMHP

The implementation of this project has been delayed. The project implementation date has been moved to January 1, 2007. Providers will be notified of the implementation as soon as information becomes available.

Due to a change in policy, effective for dates of service on or after January 1, 2007, nursing facility providers that serve clients under the STAR+PLUS program must bill for these clients through the Texas Medicaid & Healthcare Partnership (TMHP). The STAR+PLUS program will no longer be responsible for paying nursing facility providers for nursing services. Additional details will be provided to agencies in an informational letter. ■

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Reminders

How to Download and Install TDHconnect 3.0 Service Pack 8

TDHconnect 3.0 Service Pack 8 was released on May 28, 2006. TDHconnect was modified to accept the NPI for electronic LTC transactions. Providers who use TDHconnect 3.0 are encouraged to download and install Service Pack 8 from the TMHP website at www.tmhp.com.

TDHconnect users should download all previously requested responses, such as CSIs and MESAVs, before installing any service pack.

Download

Follow these steps to download the service pack:

1. Go to the TMHP website at www.tmhp.com.
2. Click the **Find Publications/File Library** link on the *"I would like to…"* list on the right side of the homepage. The TMHP File Library webpage opens.
3. Click the **TDHconnect** link. The TMHP File Library/TDHconnect webpage opens.
4. Click the **TDHconnect Updates** link. The TMHP File Library/TDHconnect/TDHconnect Updates webpage opens.
5. Click **tdhsp8** to begin installation.

Installation

To install TDHconnect service packs, follow these steps:

1. Double-click the TDHconnect 3.0 Updates Service Pack 8.msi icon. This icon was added to the desktop during the file download.
2. A dialog opens with the following message: "This will install TDHconnect 3.0 Service Pack 8. Do you want to continue?" Click **Yes** to install the TDHconnect 3.0 Service Pack 8.
3. After the TDHconnect Service Update Installation Utility window opens and the TDHconnect 3.0 Service Pack wizard opens, several informational messages will open. Read each message and click **Next** to advance to the next screen.
4. A dialog box opens with the following message: "Do you wish to backup your databases?" This will overwrite databases that are in the Backup folder. Choose one of the following options:
   - Click **Yes** to backup your databases before installing any database updates (this is the recommended choice).
   - Click **No** to continue with the installation without making backups.
5. Installation of the TDHconnect 3.0 Service Pack is complete. To view the Read Me file, check the **View Read Me** check box, and click **Finish**. The Read Me document opens.
6. Read the document, close it, uncheck the **View Read Me** check box, and click Finish.
7. When prompted to restart the computer, select "**Yes, I want to restart my computer now**," and then click **Finish**.

The next time TDHconnect is opened, the version of the service pack is listed along with the name TDHconnect 3.8.0. For more information, or help with downloading or installing service packs, contact the TMHP EDI Help Desk at 1-800-626-4117, Option 3. ■

Tips for Accessing and Downloading Information and Reports

The following are suggestions for accessing and downloading information and reports:

- To get help while using TDHconnect to complete, download, or retrieve files, press the F1 key to access the Help menu.
- Visit the News section of the TMHP website at www.tmhp.com/LTC Programs for the latest weekly postings. ■

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ER&S Reports Useful for Tracking Billing Activity

Electronic Remittance and Status (ER&S) reports are valuable tools for tracking billing activities. A successful business typically has good accounting practices, such as the reconciliation of ER&S reports. Agencies that do not reconcile their ER&S reports may be billing incorrectly, which can result in audits and penalties. It is the provider's responsibility to ensure that all billing is accurate and that any problems or issues associated with the claim are resolved within the 12-month filing limitation. If the repayment of invalid or inappropriate recoupments is not resolved within 12 months, they are subject to the 12-month filing limitation.

Providers that identify any recoupments on paid claims should verify that these are valid recoupments. It is vital that any invalid recoupment for FY 2004 services (September 1, 2003, thru August 31, 2004) be brought to the attention of appropriate State Office staff so that the services can be successfully rebilled prior to the cutoff date for the state's new fiscal year. If rebilled after the cutoff, the claim becomes a Miscellaneous Claim.

Invalid or inappropriate recoupments should be reported immediately by contacting Provider Claims Services at 1-512-490-4666, Option 3.

Providers are encouraged to download and generate their ER&S reports weekly, because each report is only available for 30 days. Use dates that begin on a Friday through the following Monday to generate a report.

ER&S reports are divided into three sections:

The *Non-Pending* section contains HIPAA-compliance information that is based on the national procedure or revenue codes submitted on the claim. It also lists any adjustments made to the total provider payment. Providers will receive one ER&S report per warrant issued for the reporting period.

The *Claim Activity* section provides information about all finalized claims and claims still pending processing or payment. Finalized claims that make it through the claims payment process are either approved to pay or denied. The section includes the derived local billing code, units paid, billed amount, paid amount, and other details. Providers will receive only one Claim Activity section per reporting period. If more than one warrant is received in a particular week, the Claim Activity section may correspond to multiple Non-Pending sections.

The Non-Pending and Claim Activity sections outline which claims were processed, the national code billed, the local bill code derived, and the payment amount for the services based on the derived bill code. This is the only way to determine whether the system derived the correct bill code for payment.

The *Financial Summary* section provides warrant information and warrant amounts for the reporting period.

To accurately assess claim activity for the reporting period, all three sections must be used.

The number of warrants issued and, indirectly, the number of Non-Pending sections to look for are provided in the Financial Summary section. ■

Providers Encouraged to Bill Electronically

It's fast. No more waiting by the mailbox or phone inquiries; know what's happening to claims in less than 24 hours and get paid for approved claims within a week. TDHconnect users can submit individual requests interactively and receive a response immediately.

It's free. All electronic services offered by TMHP are free, as well as the TDHconnect software and its technical support, upgrades, and training. TDHconnect users can access our website directly, without having to pay for an internet connection.

It's easy. TMHP offers free workshops for TDHconnect, billing, and many other topics, as well as a large library of reference materials and manuals on www.tmhp.com.

It's safe. TMHP electronic data interchange (EDI) services use virtual private networking (VPN) and secure socket layer (SSL) connections, just like the U.S. government, banks, and other financial institutions, for maximum security.

It's accurate. TDHconnect and many other software programs have features that let providers know when they've made a mistake, which means fewer rejected and denied claims. Rejected claims are returned with messages that explain what's wrong, so the claim can be corrected and resubmitted right away.

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It's there when it's needed. Electronic services are available day and night—from home, the office, or anywhere in the world.

It makes record keeping and research easy. Not only can software be used to send and receive claims, it can retrieve the Remittance and Status (R&S) report electronically, perform claim status inquiries, and archive claims. TDHconnect can generate and print reports on everything it sends, receives, and archives.

Contact the TMHP Call Center/Help Desk at 1-800-626-4117, Option 3, to order TDHconnect software. ■

Verify Eligibility With a MESAV Inquiry

A Medicaid Eligibility Service Authorization Verification (MESAV) inquiry enables providers to electronically obtain eligibility and service authorization information through TDHconnect software. DADS updates TMHP files each weekday, so the most current MESAV information is always available.

MESAV inquiries provide valuable information about each individual enrolled in the LTC Program. The inquiries enable providers to check services, units, eligibility, medical necessity, applied income/copayment, level of service in the Service Authorization System (SAS), and the effective dates for those authorizations.

Authorized providers can access information about a specific individual for a specific date range by requesting a MESAV inquiry. Information may be requested for dates spanning up to three months. The information returned may extend beyond the three-month range. Information that providers receive is based on the individual's eligibility information available through TMHP. The Claims Management System maintains confidentiality by returning information only to the provider authorized to perform requested services for that individual.

Providers should verify an individual's eligibility with a MESAV inquiry before submitting a claim, making certain that the billed dates of service fall within the effective dates of the service authorization. One of the most common reasons claims are denied is that the dates of service are not within the service authorization period. If the EOB states the individual is not authorized for services received, submit a MESAV inquiry to verify that the correct dates and services are on file with TMHP. Eligibility may have expired or be on hold.

Providers submitting paper claims on a Form 1290 can verify an individual's eligibility by contacting the TMHP Call Center/Help Desk at 1-800-626-4117, Option 1. ■

Following LTC Claim Form 1290 Guidelines Expedites Claims Processing

Providers should use the following guidelines when submitting a paper LTC Claim Form 1290:

- Print legibly.
- Do not write in cursive.
- If data is typed, use a font large enough to distinguish between characters.
- Complete all required fields.
- Use the most current LTC Bill Code Crosswalk located at www.dads.state.tx.us/business/communitycare/index.cfm
- Review the form for accuracy before submitting.
- Sign each form; an original signature is required. Copied or stamped signatures are not accepted.
- Mail Form 1290 to the following address:

Texas Medicaid & Healthcare Partnership
ATTN: Long Term Care
PO Box 200105
Austin, TX 78720-0105

Delivery to TMHP could take five business days. Allow ten business days for the claim to appear in the system.

Send overnight mail to the following address:

Texas Medicaid & Healthcare Partnership
ATTN: Long Term Care, MC-B02
12357-B Riata Trace Parkway
Austin, TX 78727

Allow three to five business days for an overnighted claim to appear in the system. Providers who contact TMHP to check the status of a claim must provide the overnight mail tracking number. ■

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Provider Resources

TMHP LTC Contact Information

The TMHP Call Center/Help Desk operates Monday through Friday, from 7 a.m. to 7 p.m., Central Time (excluding TMHP-recognized holidays).

When calling the TMHP Call Center/Help Desk, providers are prompted to enter their nine-digit LTC provider number using the telephone keypad. If calling from a rotary telephone, remain on the line for assistance. When the nine-digit LTC provider number is entered on the telephone keypad, the TMHP Call Center/Help Desk system automatically populates the TMHP representative's screen with that provider's specific information, such as name and telephone number.

Providers should have their four-digit Vendor/Facility or Site ID number available for calls about Forms 3618, 3619, and the CARE Form 3652-A.

Providers must have a Medicaid or Social Security number and a medical chart or documentation for inquiries about a specific individual.

For questions, providers should call the TMHP Call Center/Help Desk at the following telephone numbers:

- Austin local telephone number at 1-512-335-4729
- Toll-free telephone number (outside Austin) at 1-800-626-4117 or 1-800-727-5436

For questions about…		Choose…
• General inquiries • Using TDHconnect • Completing Claim Form 1290 • Claim adjustments • Claim status inquiries • Claim history	• Claim rejection and denials • Understanding R&S reports • CARE Form 3652-A • Forms 3618 or 3619 • Texas Index for Level of Effort (TILE) levels	Option 1: Customer service/ general inquiry
• Medical necessity		Option 2: To speak with a nurse
• TDHconnect—Technical issues, obtaining access, user IDs, and passwords • Modem and telecommunication issues • Processing provider agreements • Verifying that system screens are functioning	• American National Standards Institute (ANSI) ASC X12 specifications, testing, and transmission • Getting EDI assistance from software developers • EDI and connectivity • LTC Online Portal	Option 3: Technical support
• Electronic transmission of CARE Form 3652-A • Electronic transmission of Forms 3618 and 3619 • Electronic transmission of Forms 3071 and 3074 • Forms Status Inquiry	• Technical issues • Transmitting forms • Interpreting Quality Indicator (QI) Reports • Weekly Status Reports • MDS submission problems	Option 3: Technical support
• New messages (banner) in audio format for paper submitters		Option 4: Headlines/topics for paper submitters
• Individual appeals • Individual fair hearing requests	• Appeal guidelines	Option 5: Request fair hearing
• Replay for menu options		Option 6: Replay options

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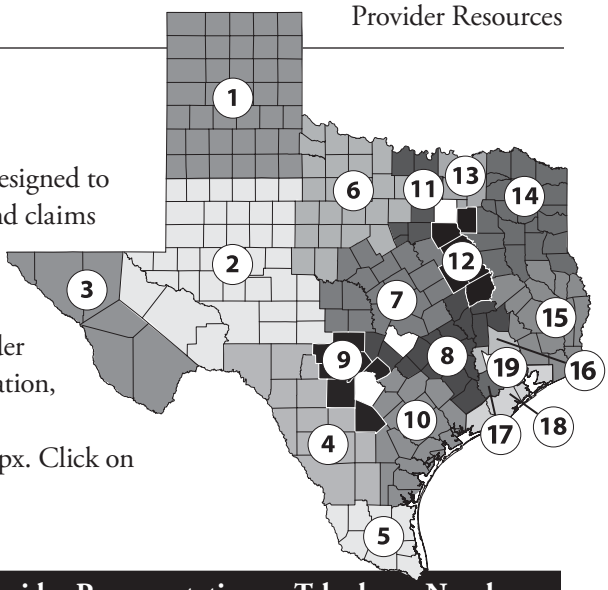
TMHP Provider Relations Representatives

TMHP provider relations representatives offer a variety of services designed to inform and educate the provider community about TDHconnect and claims filing procedures. Provider relations representatives assist providers through telephone contact, on-site visits, and scheduled workshops.

The map to the right and the following table indicate TMHP provider relations representatives and the areas they serve. Additional information, including a regional listing by county and workshop information, is available on TMHP website at www.tmhp.com/Providers/default.aspx. Click on the Regional Support link, and then choose the applicable region.



Territory	Regional Area	Provider Representative	Telephone Number
1	Amarillo, Childress, and Lubbock	Elizabeth Ramirez	1-512-506-6217
2	Midland, Odessa, and San Angelo	Mindy Wiggins	1-512-506-3423
3	Alpine, El Paso, and Van Horn	Isaac Romero	1-512-506-3530
4	Del Rio, Eagle Pass, and Laredo	Candice Myers	1-512-506-7271
5	Brownsville, Harlingen, and McAllen	Cynthia Gonzales	1-512-506-7991
6	Abilene and Wichita Falls	Matthew Cogburn	1-512-506-7095
7	Brady, Brownwood, Hospitals in Travis County, Round Rock, and Waco	Andrea Daniell	1-512-506-7600
8	Austin, Bryan, College Station, and Wharton	Will McGowan	1-512-506-3526
9	San Antonio and Kerrville	Sue Lamb	1-512-506-3422
10	San Antonio, Corpus Christi, and Victoria	Jill Ray	1-512-506-3554
11	Cleburne, Denton, and Fort Worth	Rita Martinez	1-512-506-7990
12	Dallas, Corsicana, and Groesbeck	Sandra Peterson	1-512-506-3552
13	Dallas and Whitesboro	Olga Fletcher	1-512-506-3578
14	Tyler, Texarkana, and Paris	Trilby Foster	1-512-506-7053
15	Beaumont and Lufkin	Gene Allred	1-512-506-3425
16	Houston and Conroe	Linda Wood	1-512-506-7682
17	Houston and Katy	Rachelle Moore	1-512-506-3447
18	Galveston and Matagorda	John Miller	1-512-506-3586
19	Houston	Stephen Hirschfelder	1-512-506-3446

Helpful Information Available on LTC Websites

LTC Program information is available on the TMHP website at www.tmhp.com/LTC Programs.

On the DADS website at www.dads.state.tx.us, providers can:

- Access mental retardation services information.
- Access Community Care Information Letters at www.dads.state.tx.us/business/communitycare /infoletters/index.cfm under Community Care Information Letters.
- Access information for nursing facilities and therapy providers at www.dads.state.tx.us/business/ltc-policy /index.cfm under Communications.
- Access the LTC Bill Code Crosswalk at www.dads.state.tx.us/business/communitycare /index.cfm under Community Care Programs.
- Access LTC messages and alerts. ■

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DADS Contact Information

If you have questions about…	Contact…
12-month claims payment rule	Provider Services (Community Care for Aged and Disabled Programs [CCAD])—Contract Manager Institutional Services (NFs)—Provider Claims Services: 1-512-490-4666, Option 1 MR Services—Provider Claims Services: 1-512-490-4666, Option 1
Contract enrollment	Provider Services (CCAD): 1-512-438-3875 Institutional Services: 1-512-438-2546 Hospice Services: 1-512-438-2546 MR Services: 1-512-438-3544
Cost report information (days paid and services paid)	Use TDHconnect to submit a batch of CSIs.
Rate Analysis Contacts	Website: www.hhsc.state.tx.us/medicaid/programs/rad/index.html Click the Long Term Care link and then select the appropriate program.
How to prepare a cost report (forms and instructions)/ approved rates posted	Website: www.hhsc.state.tx.us/medicaid/programs/rad/index.html
How to sign up for or obtain direct deposit/electronic funds transfer	Accounting: 1-512-438-4310, 1-512-438-5595, or 1-512-438-4684
Medicaid eligibility and name changes	Medicaid Eligibility (ME) Worker Integrated Eligibility and Enrollment (IEE) Call Center at telephone number 211 Website: www.hhs.state.tx.us/consolidation/IE/IE.shtml
Obtaining a copy of LTC Claim Form 1290	Contract Manager or Website: www.dads.state.tx.us/business/communitycare/infoletters/index.cfm under Community Care Information Letters
Deductions and provider-on-hold questions	Provider Services (CCAD)—Contract Manager Institutional Services (NFs)—Provider Claims Services: 1-512-490-4666, option 3 Website: http://ausmis31.dhs.state.tx.us/cmsmail MR Services: 1-512-438-3544
Status of warrant/claim after it has been transmitted to Accounting (fiscal) by TMHP	Accounting: 1-512-438-3989 When calling Accounting, provide the document locator number [DLN] number assigned by TMHP. Comptroller's website: https://ecpa.cpa.state.tx.us Choose the State-to-Vendor-Payment Info-Online-Search link.
Texas State University Texas Index Level of Effort (TILE) training	The Office of Continuing Education: Online course: 1-512-245-7118 or 1-512-245-2507 (correspondence course and general information) Website: www.txstate.edu/continuinged
TILE Calculator	HHSC website located at www.hhsc.state.tx.us/medicaid/programs/rad/nf
Third Party Resources (TPR)/TORT	Provider Claims Services: 1-512-490-4666, option 4 Website: http://ausmis31.dhs.state.tx.us/cmsmail

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If you have questions about…	Contact…
Community Care for the Aged and Disabled Programs (CCAD), Community-Based Alternatives (CBA), Community Living Assistance and Support Services (CLASS), Deaf-Blind with Multiple Disabilities (DB-MD), Medically Dependent Children Program (MDCP), Consolidated Waiver Program (CWP), Home and Community Based Services (HCS), Texas Home Living Waiver (TxHml), and Hospice Programs	
CLASS Program CLASS Interest Line	Program Consultant 1-877-438-5658
DB-MD Program DB-MD Interest Line	1-512-438-2622 1-877-438-5658
CBA/CCAD financial or functional eligibility criteria	Caseworker or Case Manager
CBA/CCAD Program policies/procedures	Contract Manager
Hospice policy questions	1-512-438-3169
Hospice Program service authorization issues	Provider Claims Services: 1-512-490-4666, option 1 Website: http://ausmis31.dhs.state.tx.us/cmsmail
Medically Dependent Children Program (MDCP)	1-512-438-5391
HCS and TxHml billing, policy, payment reviews	Billing: Gaynell Bray 1-512-438-3612 Prior approval AA/MHM/Dental: Sean Ivie 1-512-438-3598
Intermediate Care Facility for the Mentally Retarded (ICF-MR) Nursing Facility Program	
Cost report payments/quality assurance fee (QAF)	1-512-491-1739
Health and Human Services Commission Network (HHSCN) connection problems	1-512-438-4720
ICF-MR/durable medical equipment (DME), DME authorizations, Home Community-Based Services (HCS), Texas Home Living Waiver (TxHmL), home modifications, adaptive aids, and dental services approvals	1-512-490-4642 or 1-512-490-4651
ICF-MR/Residential Care (RC) individual movements/ service authorization questions	Provider Claims Services: 1-512-490-4666, option 1 Fax: 1-512-490-4669 Website: http://ausmis31.dhs.state.tx.us/cmsmail
Client Assessment Registration System (CARE) Help Desk	1-512-438-4720
Program enrollment for utilization review (UR)/usual, customary utilization control (UC), Purpose codes, and MRC Assessment Form, level of service, level of need, level of care, and ICAP	1-512-438-5055 Fax: 1-512-438-4249
Provider contracts and vendor holds for ICF-MR	1-512-438-3544
Provider systems access for ICF-MR CARE forms	ICF/MR: 1-512-438-3554 HCS: 1-512-438-5428
CARE Form 3652-A and Forms 3618 and 3619 missing/incorrect information	Provider Claims Services: 1-512-490-4666, Option 1 Website: http://ausmis31.dhs.state.tx.us/cmsmail
Rehabilitation specialized/emergency dental authorizations	1-800-792-1109 Fax: 512/490-4620
Service authorizations for Nursing Facilities	Provider Claims Services: 1-512-490-4666, Option 1 Fax: 1-512-490-4669 Website: http://ausmis31.dhs.state.tx.us/cmsmail

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Bulletin Article Resources

The Bulletin Article Resource table includes a list of previously published articles in the order of the bulletin edition in which they appeared, starting with February 2005. Providers may use this table as a resource for referencing previously published articles.

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Error and Suspense Reports Available for Medicaid-Certified Nursing Facility Providers	February 2005, No. 21	2
TMHP's Intent to Discontinue Support of Windows® 95	February 2005, No. 21	3
TDHconnect 3.0 Service Pack 5 Release	February 2005, No. 21	3
Medicaid Eligibility Service Authorization Verification (MESAV) Inquiries	February 2005, No. 21	4
Use of Modifiers for Transition Assistance Services (TAS)	February 2005, No. 21	4
Medically Dependent Children's Program (MDCP)—Availability of Units	February 2005, No. 21	5
Community Living Assistance and Support Services (CLASS)—Form Completion	February 2005, No. 21	5
Most Frequently Asked Questions for This Quarter • "T" claims showing up on R&S report • Vendor/Facility Site ID number • Downloading the (CARE) Weekly Status Report • Approved MN forms not showing up on SAS	February 2005, No. 21	5
Accessing the Remittance and Status (R&S) Report Through TMHP Website	February 2005, No. 21	6
Medical Necessity Weekly Status Report	February 2005, No. 21	6
Purpose Code E Reminders	February 2005, No. 21	7
2005 LTC User Manual to Be Mailed to Paper Submitters	May 2005, No. 22	2
Tentative Release of TDHconnect 3.0 Service Pack 6 Scheduled	May 2005, No. 22	2
New Security Features Enhance TMHP Website	May 2005, No. 22	3
In This Corner • 3652 CARE Forms • Tips for Completing the 3652 CARE Form	May 2005, No. 22	4
Top Three Reasons Why Claims Deny	May 2005, No. 22	5
Providers Verify Eligibility with a MESAV Inquiry	May 2005, No. 22	6
Most Frequently Asked Questions During This Quarter • EOB 250—Late Billing—Must be filed within 12 months from the end of the service month • "T" Miscellaneous Claims—Recoupment • Vendor/Facility Site ID number	May 2005, No. 22	7
TDHconnect Training Materials Available	August 2005, No. 23	3
Changes to Electronic Data Interchange Agreements	August 2005, No. 23	3
Changes in the Community Living and Support Services (CLASS) Program	August 2005, No. 23	3
Most Frequent Asked Questions During This Quarter Answered • TIERS Impact • Primary Home Changes to Priority Level • Claims Status Inquiries	August 2005, No. 23	5

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Article Name	LTC Bulletin	Page #
Most Frequently Used Reports • Processed 3652 CARE Forms Shown in Medical Necessity Weekly Status Report • Error and Suspense Reports Available for Medicaid-Certified Nursing Facility Providers	August 2005, No. 23	7
Providers' Survey TDHconnect Training	November 2005, No. 24	1
Release of TDHconnect 3.0 Service Pack 7	November 2005, No. 24	2
Performing a Claims Status Inquiry	November 2005, No. 24	3
Accessing Managed Care Information	November 2005, No. 24	3
Publishing National Code Descriptions	November 2005, No. 24	3
Most Frequently Asked Questions During This Quarter Answered • What process should a provider follow when requesting an onsite visit or TDHconnect training from a TMHP provider relation's representative? • How many days does a TMHP provider relations' representative have to return calls? • What process should a provider follow when the agency does not receive a return call from a TMHP provider relations' representative within the 48-business hour timeframe?	November 2005, No. 24	4
LTC Crosswalk Updates	February 2006, No. 25	2
Hurricane Katrina–Waiver and Claims Processing	February 2006, No. 25	2
CARE Form System Software Update	February 2006, No. 25	2
Results of the TDHconnect Survey	February 2006, No. 25	3
Deaf-Blind Multiple Disabilities (DB-MD) Medicaid Waiver Program	February 2006, No. 25	4
Bulletin Article Resources–Annual Update	February 2006, No. 25	5
National Provider Identifier (NPI) Update	February 2006, No. 25	5
Answers to this Quarter's Most Frequently Asked Questions • If a provider has a billing problem, what is the first step in resolving the billing problem? • When should a provider contact TMHP? • When should a provider call his caseworker about a billing problem?	February 2006, No. 25	6
Where to Find the LTC Glossary of Terms	May 2006, No. 26	2
How to Apply for an NPI	May 2006, No. 26	6
Tips for Completing the 3652-A CARE Form	May 2006, No. 26	8
Release of TDHconnect 3.0 Service Pack 8	May 2006, No. 26	9
New Address for Submission of Purpose Codes U	August 2006, No. 27	2
Learn about the Loss of Eligibility Report	August 2006, No. 27	2
The CFS will be replaced by the LTC Online Portal	August 2006, No. 27	2
Answers to This Quarters Most Frequently Asked Questions • Rate Changes • Billing Problems • Claims Status Inquiry (CSI)	August 2006, No. 27	7

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